



## **National Pressure Ulcer Advisory Panel (NPUAP) Recommendations For Coding Suspected Deep Tissue Injury on MDS 2.0**

Suspected Deep Tissue Injury (sDTI), a category/stage for certain pressure ulcers, is becoming more apparent as clinicians observe its appearance and clinical manifestations. This type of pressure ulcer/tissue destruction has had an increase in recognition among clinicians in long term care (LTC)/skilled nursing facilities (SNFs) since the 2004 revisions by the Centers for Medicare and Medicaid Services (CMS) of the F-Tag 314. F-314 supports the existence of sDTI and addresses the likely unavoidable decline in the area of sDTI. In 2007, the NPUAP added Suspected Deep Tissue Injury (sDTI) as a stage/category, further increasing clinical recognition in all settings.

The Minimum Data Set, Version 2.0 (MDS 2.0) was created prior to 1996 and does not currently recognize the category 'sDTI'. Coding of sDTI is a challenge since the Resident Assessment Instrument (RAI) User's Manual does not provide instruction for this category. In attempt to comply with the MDS 2.0, coders have struggled to stage sDTI according to the RAI definitions. Given the absence of sDTI in the RAI, this has resulted in varying interpretations for coding sDTI. Until the RAI provides an update with guidance, this NPUAP document serves as a guide for MDS coders to complete the MDS 2.0 in a standardized manner. This will in turn foster agreement between assessors.

In order to recognize the difference between the MDS 2.0 stage and the clinical stage/category (and as suggested in the RAI) documentation should support both the MDS stage and the clinical stage/category for every pressure ulcer. It is important to recall that the NPUAP stage/category refers to the clinical level of injury, where as the MDS 2.0 stage refers to the visible appearance used to reflect healing. Due to this disparity, the NPUAP stage/category cannot be used on the MDS 2.0 and will often differ from the MDS 2.0 stage. Refer to the RAI manual for details. These conflicts may be rectified in the upcoming MDS 3.0. However, until that release, the current MDS 2.0 must be completed according to Medicare/RAI manual instructions. The following information compares the expected clinical findings (i.e., the clinician's description of the appearance of the wound), MDS 2.0 coding recommendations, and basic treatment recommendations.

**DTI: Clinical Tips:**

<b>NPUAP (Clinical)</b>	<b>MDS 2.0 (RAI) Code</b>	<b>TREATMENT RECOMMENDATIONS</b>
<p><b>Suspected Deep Tissue Injury:</b> Purple or maroon localized area of discolored intact skin (or blood-filled blister see below) due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.</p>	<p><b>Code: Stage I</b> for purple or maroon localized area of discolored skin            Rational: At this time, pressure ulcers with intact skin can be either a Stage I or a DTI in evolution. The appearance of Stage I with ‘red discolored skin that presents with a subtle purplish hue in ebony skin’ can be difficult to distinguish from sDTI that appear ‘purple or maroon’. At this time, technology is not readily available in all settings to determine the true depth of injury, so without a current sDTI coding option, coding as a Stage I presents an option with least error. Additionally, the treatment interventions are similar. Keep in mind that actual Stage I ulcers are likely to improve with appropriate care, where as sDTI in evolution are likely to rapidly decline despite appropriate care. The visible stage should then be provided on the MDS 2.0.</p>	<p><b>Intact Skin:</b></p> <ul style="list-style-type: none"> <li>• Remove the cause of pressure, shear, and/or friction.</li> <li>• For heel ulcers, off-loading devices may be helpful.</li> <li>• Provide appropriate redistributing surfaces for bed and chair.</li> <li>• Keep skin intact.</li> <li>• Provide a moisture barrier or skin sealant.</li> <li>• Observe at least daily for any changes and treat appropriately.</li> <li>• Provide education to patient, healthcare decision maker, and care-giver regarding anticipated changes/decline.</li> </ul>
<p><b>Blood-filled blister</b>            DTI may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark ulcer bed. The ulcer may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.</p>	<p><b>Code: Stage-Unstageable/Stage IV</b>            Rational: Blisters that are serum filled are visibly superficial; however, the blood-filled blister indicates a rupturing of vessels that obscures the depth, resulting in an unstageable situation. In rare cases smaller blood blisters may reabsorb. In most cases blood blisters deteriorate to necrosis or rupture to reveal full thickness injury despite appropriate care. The sDTI should be restaged according to the appearance at that time.</p>	<ul style="list-style-type: none"> <li>• Off-load blister (heel lifting devices may be helpful).</li> <li>• For sacral ulcers, provide pressure redistributing bed/chair surfaces.</li> <li>• Remove cause of pressure, friction, and/or shear.</li> <li>• Keep blister intact, moisture barriers and/or skin sealants may be helpful. A protective dressing may be considered.</li> <li>• Observe at least daily for any changes and treat appropriately.</li> <li>• Provide education to patient, healthcare decision maker, and care-giver regarding anticipated changes/decline.</li> </ul>

- sDTI in evolution warrants further documentation by MD, PA, NP, CWOCN, CWCN, RN, PT, or CWS: Describe the DTI in detail. F-314 recognizes that DTI is likely to decline despite good care and pressure redistribution. Document all interventions provided to remove/redistribute pressure and support healing. Provide education to patient and family regarding both anticipated evolution and interventions.
- Evidence of sDTI may impact the MDS 2.0 ‘Assessment Reference Date.’ Evolution may lead to observation of the actual level of injury within days and selection of ARD may consider the possibility of capturing a full thickness ulcer. Should DTI further evolve and the level of injury become apparent, provide the ‘Observed’ stage for the MDS 2.0 accordingly.
- Written documentation should include descriptive, objective and thorough information pertaining to the ulcer/lesion in question. To support the clinical presentation of the ulcer and MDS 2.0 coding issues, consider the following examples for documenting DTI.
  - A sDTI presents on the sacrum with intact, purple discolored skin with elevated periwound temperature and fluctuance. Area has been coded as a Stage I for MDS 2.0 due to intact skin at the time of observation.
  - A sDTI presents on the right heel with evidence of blood blister and emerging necrosis. Ulcer/lesion considered Unstageable at this time as depth cannot be viewed, and is coded as a Stage IV for MDS 2.0 at the time of observation.
  - DTI leads to a sloughing of the epidermis, which looks like a peeling sunburn, this presentation should also be described and coded as an unstageable or stage IV pressure ulcer. The tissue bed remains dark (devitalized) in these ulcers and it should not be staged as a stage II, despite the thin blister present.

For more information, contact the NPUAP at [www.npuap.org](http://www.npuap.org)